Mangum Regional Medical Center

TITLE		POLICY
Management of the Agitated/Aggressive/Disturbed Patient		**EMD-010**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department/Nursing Services		

I. SCOPE

To ensure the safety and security of all patients, visitors and staff, the policy of Mangum Regional Medical Center shall be to effectively manage patients who display agitated, aggressive or disturbed behaviors.

II. PURPOSE

The purpose of this policy is to manage any occurrence of agitation, aggression, violence, and/or behavioral disruption in the emergency department and create a safe and therapeutic environment. The safety and security of all patients, visitors, and staff are a priority. Mangum Regional Medical Center will not tolerate violent or threatening behavior by anyone and will impose penalties appropriate to the nature and severity of the violation.

To strongly discourage disruptive or violent behavior, hospital staff will work cooperatively with law enforcement agencies to make reports and file criminal charges (if deemed necessary).

III. DEFINITIONS

A. Agitated means an unpleasant state of extreme arousal and behavioral dyscontrol that will likely result in harm to the patient or healthcare workers without intervention. Often agitation can fall along a continuum and can range from mild agitation resulting in feelings of being excited or stirred up to severe agitation leading to harmful aggressiveness and destructive behaviors.

B. Aggressive behavior means behaviors that are intended to harm another individual who does not wish to be harmed.

C. Disruptive behavior means the use of profane, loud and offensive language or any other action that disrupts the normal operations of the ED and potentially jeopardizes the safe delivery of emergency care to others.

D. Violent behaviors means any intentional act or threat of harm by one individual to another. Assault is any threat of harm including a physical gesture such as waving a clenched fist. Battery is when a person intentionally or knowingly, without justification, and by any means causes bodily harm to an individual or makes physical contact of an

insulting or provoking nature (i.e. hitting, spitting, kicking, etc.). Aggravated Assault and Battery occurs when the above occurs and a weapon is involved, or the victim was an ED worker. "Aggravated" is synonymous with a felony and is subject to more harsh penalties.

E. Close Observation means one competent observer to one or more patients in the same room/area.

F. Competent staff means those who have completed a facility-based competency assessment initially and ongoing basis related to core elements required to monitor a patient under self-harm precautions.

G. A chemical restraint does not include medications used as a standard treatment for patient's medical or psychiatric condition, such are excluded from the standards for chemical restraint use. A standard treatment is defined as a medication used to address a patient's medical or psychiatric condition and include but are not limited to the following:

    1. The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer, for the indications it is manufactured and labeled to address, listed dosage parameters, etc.
    2. The use of the medication follows national practice standards established or recognized by the appropriate medical community and/or professional medical association or organization.
    3. The use of the medication to treat a specific patient's clinical condition is based on that patient's target symptoms, overall clinical situation, and on the provider's knowledge of that patient's expected and actual response to the medication.
    4. An additional component of "standard treatment" for a medication is the expectation that the standard use of a psychotherapeutic medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around him or her than would be possible without the use of medication. Psychotherapeutic medications are to enable, not to disable. If a psychotherapeutic medication reduces the patient's ability to effective or appropriately interact with the world around him or her, then the psychotherapeutic medication is not being used as a "standard treatment" for the patient's condition. Examples of standard treatment:
        - Clinical treatment of patients who are suffering from serious mental illness who need appropriate therapeutic doses of psychotropic medication to improve their level of functioning.
        - Appropriate doses of sleeping medication prescribed for patients with insomnia.
        - Anti-anxiety medication that is prescribed to calm a patient who is anxious.

IV. POLICY

The approach to the care of patients presenting with agitation, aggression, self-harming, violent, and/or disturbing behaviors is multidisciplinary. At a minimum all patients who present to the Emergency Department (ED) will be assessed using the Emergency Severity Index (ESI) (See EMD-006A) to determine the severity of the patients illness and assign priorities of care to be provided. The patient will place under close observation at all times by a **competent** health care provider who is responsible for monitoring the patient.

A. Inclusion Criteria

1. Patients who present with acute agitation, aggressive, self-harming, violent and/or disturbed behaviors.
2. Develop agitation, aggressiveness, self-harming, violent and/or disturbed behaviors during ED admission.
3. Agitation can progress in stages:
    a. Verbal stage: use of general threats and/or abusive language.
    b. Motor stage: remains in a constant state of motion (i.e. pacing).
    c. Property damage: destructive, throwing items, breaking objects.
    d. Attack stage: self-harming, attempting to harm others.

B. Triage Considerations

1. All patients upon presentation to the ED should be initially triaged using the Emergency Severity Index (ESI).
2. The triage assessment and triage level must be documented in the appropriate area of the **[insert name of appropriate form or flowsheet]**, including the date and time the assessment was completed.

C. Assessment (See Aggressive/Agitated/Disturbed Patient Order Protocol Attachment A)

1. The physician/mid-level provider responsible for the patient's care will perform an appropriate Medical Screening Examination (MSE) including any tests (i.e. labs, diagnostic imaging, etc.), to rule out a medical illness as the cause for or contributing to the patient's mental condition.
2. Nursing staff should perform and document a focused nursing assessment to rule out any medical conditions that may be contributing to the patient's mental condition. Assessment should include a psychosocial assessment of the patient.
3. Constant monitoring and frequent reassessment of the patient treated with medications or physically restrained, to optimize patient safety and to determine the earliest possible time for discontinuation or removal of these non-risk-free interventions.
4. Vital signs every 30 minutes unless otherwise ordered by the physician/mid-level provider or patient is in physical restraint, has received calming medications (chemical restraint) or based on patient's medical condition.

D. Laboratory and Diagnostic Studies

1. Lab and diagnostic studies that may be considered in the management of the aggressive/agitated/disturbed patient (See Aggressive/Agitated/Disturbed Patient Order Protocol):
    a. Finger stick blood sugar (FSBS)
    b. Urine β-hCG (pregnancy test)
    c. Complete blood count (CBC)
    d. Comprehensive metabolic panel (CMP)
    e. Total CK
    f. Ethanol Level
    g. Urine analysis (UA)
    h. Thyroid stimulating hormone (TSH)
    i. Serum Salicylate Acid
    j. Serum Acetaminophen Level

E. De-escalation Methods

1. De-escalation should be attempted prior to the use of medication or physical restraint.
2. Top 10 Tips for De-escalation
    a. Be Empathic and Nonjudgmental
        a. When someone says or does something you perceive as weird or irrational, try not to judge or discount their feelings. Whether or not you think those feelings are justified, they're real to the other person. Pay attention to them. Keep in mind that whatever the person is going through, it may be the most important thing in their life at the moment.
    b. Respect Personal Space
        i. If possible stand 1.5 to 3 feet away from a person who's escalating. Allowing person space tends to decrease a person's anxiety and can help you prevent acting-out behavior. If you must enter someone's personal space to provide care, explain your actions so the person feels less confused and frightened.
        ii. If possible, before interacting with the agitated person, call for help so that help is on the way.
        iii. Place yourself (always keep yourself) between the person and the exit.
    c. Use Nonthreatening Nonverbals
        a. The more a person loses control, the less they hear your words, and the more they react to your non-verbal communication. Be mindful of your gestures, facial expressions, movements and tone of voice. Keeping your tone and body language neutral will go a long way toward defusing a situation.
    d. Avoid Overreacting
        a. Remain calm, rational and professional. While you can't control the person's behavior, how you respond to their behavior will have a direct effect on whether the situation escalates or defuses. Positive thoughts like "I can handle this" and "I know what to do" will help you maintain your own rationality and calm the person down.

e. Focus on Feelings
    a. Facts are important, but how a person feels is the most critical. Yet some people have trouble identifying how they feel about what's happening to them. Watch and listen carefully for the person's real message. Try saying something like, "That must be scary". Supportive words like these will let the person know that you understand what's happening, and you may get a positive response.
f. Challenging Questions
    a. Answering challenging questions often results in a power struggle. When a person challenges your authority, redirect their attention to the issue at hand. Ignore the challenge, but not the person. Bring their focus back to how you can work together to solve the problem.
g. Set Limits
    a. If a person's behavior is belligerent, defensive, or disruptive, give them clear, simple, and enforceable limits. Offer concise and respectful choices and consequences. A person who's upset may not be able to focus on everything you say. Be clear, speak simply, and offer the positive choice first.
h. Choose Wisely What You Insist Upon
    a. It's important to be thoughtful in deciding which rules are negotiable and which are not. For example, if a person doesn't want to shower in the morning, can you allow them to choose the time of day that feels best for them? If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations.
i. Allow Silence for Reflection
    a. We've all experienced awkward silences. While it may seem counterintuitive to let moments of silence occur, sometimes it's the best choice. It can give a person a chance to reflect on what's happening, and how he or she needs to proceed. Silence can be a powerful communication tool.
j. Allow Time for Decisions
    a. When a person is upset, they may not be able to think clearly. Give them a few moments to think through what you've said. A person's stress rises when they feel rushed. Allowing time brings calm.

2. History is critically important in determining whether the source of agitation, aggression, self-harming, violent and/or disturbing behavior is likely related to a general medical condition such as hypoxia or neurological problem versus an exacerbation of a psychiatric illness.
3. Identifying the underly etiology is key to treating agitation, aggression, self-harming, violent and/or disturbing behavior in the ED setting.
4. When working with patients with agitation, aggression, self-harming, violent and/or disturbing behavior there are four (4) main objectives:
    a. Ensure the safety of the patient, staff, and others in the immediate area.

b. Help the patient manage their emotions, distress and maintain or regain control of their behavior.
c. Avoid the use of restraints (mechanical, chemical and/or physical hold) when all possible.
d. Avoid coercive interventions that escalate agitation, aggression, self-harming, violent and/or disturbing behaviors.

5. Methods of verbal de-escalation may include but are not limited to the following interventions:
   a. Respect the patient's personal space.
   b. Maintain calm speech, demeanor, and facial expression.
   c. Establish verbal contact (designate one staff member to directly communicate and interact with the patient whenever possible).
   d. Listen closely to what the patient is saying.
   e. Be concise.
   f. Identify wants and feelings.
   g. Find a way to respond that agrees with or validates the patient's position.
   h. Explain to the patient what you want them to do.
   i. Clearly inform the patient of acceptable behaviors.
   j. Set clear limits.
   k. Offer choices and optimism.
   l. Show kindness (offer blankets, magazines, food, beverage if not contraindicated by environmental safety check or medical condition).
   m. Never promise the patient something that cannot be delivered.
   n. Stand at an angle from the patient, hands should be visible.

F. Restraint Use

1. Progress from the least restrictive (environmental alterations) to most restrictive (medications or physical restraints), unless safety is immediately at risk.
2. Goal should be to use physical restraints as a "last resort" and as a bridge to chemical restraint. Typically, the use of restraints should be used no longer than 5 to 15 minutes with the appropriate dosing of medication.
3. Placing the patient in a physical hold in order to provide calming medications (chemical restraint) is one option to avoid the use of physical restraints. Another option would be to place the patient into physical restraints for a short period to administer intramuscular (IM) calming medications (chemical restraint) and release the patient immediately upon becoming calm.
4. The use of physical restraints should always be followed by the use of calming medications.
5. Avoid covering an agitated, aggressive, violent and/or disturbed patient's mouth and/or nose with a gloved hand. This can lead to asphyxia, metabolic acidosis, and death. Use an oxygen mask to prevent the patient from spitting on staff.
6. If the use of four-point restraints are necessary, place the patient in the supine position with 30-degree head of bed elevation, restraints tied to the bed frame (rather

than the side rails) and one arm above the head and the other below the waist.

G. Chemical Restraint or Sedation

1. The goal of calming medication is to enable rapid stabilization of the acutely agitated patient and to enable the expeditious search for potential life-threatening medical conditions that could be contributing to the patient's behavior.
2. See the Standardized Use of Restraints Policy PTR-002 for the use of chemical restraint or sedation.

H. Admission or Discharge/Transfer Criteria

1. Admit to inpatient medical floor:
   a. Evidence of etiology of agitation or co-morbid condition requiring medical management
   b. Medication side-effects requiring acute monitoring and/or treatment in an in-patient setting.
   c. Social situation preventing a safe return to home.
2. Discharge/Transfer to higher level of care or acute psychiatric facility:
   a. Ongoing, uncontrolled or poorly controlled agitation, aggression, self-harming, or violent behavior.
   b. Respiratory depression after medical therapy for agitation.
   c. History or laboratory evidence of life-threatening ingestion (in consultation with poison control).
   d. Agitation caused by an unknown or unconfirmed etiology.
   e. Suicidal or homicidal ideation.
   f. Drug overdose, intentional or accidental.
   g. Behavior concerns rendering outpatient management unsafe or impractical.

V. REFERENCES

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VI. ATTACHEMENTS

See EMD-006A-ESI Triage Algorithm
Attachment A: Aggressive/Agitated/Disturbed Patient Order Protocol

REVISIONS/UPDATES

Date	Brief Description of Revision/Change